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I GENERAL INFORMATION

SECTION 1 PURPOSE OF MANUAL

The Texas Department of Health (TDH) Family Planning Policy and Procedure Manual for Title X and Title XX Contractors was developed to guide contractors of the TDH Family Planning Division and TDH regional staff regarding Division policies and related information. Providers of family planning services who are reimbursed by Medicaid (Title XIX) or are Title V contractors for family planning services must follow policies and procedures as established by the TDH Title V Program and/or the Texas Medicaid Program.

Contractors that receive Title X funds have an additional obligation to adhere to the guidelines issued by the United States Department of Health and Human Services, Office of Population Affairs. (See appendices for the Office of Family Planning Program Guidelines For Project Grants For Family Planning Services.)

Federal and state laws related to reporting of child abuse, operation of health facilities, professional practice, insurance coverage, and similar topics also impact family planning services. Contractors are required to be aware of and in compliance with existing laws. (See appendices for Texas law pertaining to reporting child abuse.)

The state rules that apply most specifically to family planning services in Texas are found in the Texas Administrative Code (TAC), Title 25, Part I, Chapter 56. In this manual, excerpts taken word-for-word from the TAC are enclosed in a box and identified by chapter and section number. (See appendices for TAC Title 25, Health Services, Part I, Texas Department of Health, Chapter 56, Family Planning.)

For additional information about TDH family planning, access the TDH Women's Health internet website at http://www.tdh.state.tx.us/women/index.htm . Electronic versions of the TAC, federal Title X Program Guidelines, links to other TDH programs' websites, and other useful information are available through the website. Website content that is applicable only to TDH contractors can be selected by using a password issued to contractors.

SECTION 2 DEFINITIONS

§ 56. 2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings.

Board—The Texas Board of Health

Client—Any individual seeking assistance from a Texas Department of Health contractor or provider to meet their family planning goals.

Committee—The Family Planning Advisory Committee.

Contraception—The means of pregnancy prevention. Methods include permanent methods and temporary methods.

Contractor—Any entity that contracts with the Texas Department of Health to provide Title V, X, and/or XX family planning services

Department—The Texas Department of Health.

DHS—The Texas Department of Human Services.

Family planning—The process of establishing the preferred number and spacing of one's children, selecting the means to achieve the goals, and effectively using that means.

Family planning services—A public health care system targeting low-income women, men, and adolescents that is designed to enable people voluntarily to limit their family size or to space their children.

Intended pregnancy—Pregnancy a woman reports as timed well or desired at the time of conception.

Medicaid—Title XIX of the Social Security Act

Provider—Any entity that receives Texas Department of Health funding to provide family planning services.

Region—Any of the public health regions established by the Texas Department of Health.

Title V family planning program—Grants for the provision of family planning services under the Maternal and Child Health Act, 42 United States Code § 701 *et seq*.

Title X family planning program—Grants for the provision of family planning services under the Public Health Service Act, 42 United States Code § 300 *et seq*.

Title XIX family planning program—Family planning services provided under Title XIX (Medicaid) of the Social Security Act, 42 United States Code § 1396 *et seq*.

Title XX family planning program—Grants for the provision of family planning services provided under the Social Services Block Grant, 42 United States Code § 1397 *et seq*.

SECTION 3 FUNDING SOURCES/AVAILABILITY

The Family Planning Division administers three sources of funding, **Titles X, XX and XIX** (Medicaid). Titles X and XX are allocated through a competitive contracting process. Funds are provided to private or public non-profit agencies to support preventive medical and educational family planning services. The Family Planning Division contracts with a variety of organizations to provide family planning services, including local health departments, medical schools, hospitals, private non-profit agencies, and community and rural health centers. Several TDH regional clinics also provide family planning services.

Title X

Congress passed the Family Planning Services and Population Research Act in 1970, adding Title X to the Public Health Services Act. Title X funding is used to pay infrastructure development and operating costs for family planning agencies. (Federal regulation citation: Title X, Public Health Service Act [42 USC § 300 et. seq.], 42 CFR, Part 59, Subpart A, Project Grants and Contracts for Family Planning Services)

Title XIX

Medicaid (Title XIX of the Social Security Act) was created by Congress in 1965. The Family Planning Division requires all agencies that receive Title X or Title XX family planning funding through TDH also to be enrolled providers of services to Medicaid-eligible women and men. (Federal regulation citation: Title XIX, Social Security Act, [42 USC § 1396-1396v et. seq.] Grants to States for Medical Assistance Programs)

Title XX

Title XX or the Social Services Block Grant (SSBG) is the social services component of the Social Security Act. Title XX funds are used to provide individual and community-wide educational activities as well as direct medical care. Title XX SSBG funds are supplemented by TANF funds as authorized by the legislature. (Federal regulation citation: Title XX, Social Security Act [42 USC § 1397a et. seq.], Block Grants to States for Social Services)

SECTION 4 CONTRACTOR SELECTION PROCESS

Family Planning contractors must apply for Title X and XX funding through the TDH's competitive Request for Proposals (RPF) process. TDH announces RFPs for public health services on the Electronic State Business Daily, also known as the "Texas Marketplace." All applicants must submit all forms as requested in the RFP to be considered for funding. The TDH Family Planning Division reviews applications for family planning funds using a standardized review tool, and makes funding decisions. The specific dollar amount awarded to each applicant depends upon the merit and scope of the proposed project(s), the number of women in need in the area, agency/clinic capacity, and the existence of other providers. Once decisions are made, TDH enters into agreements (contracts) with approved applicants to provide family planning services. Contractors are funded for a 12-month budget period within a project period of three (3) to five (5) years.

Contractors must re-apply annually through a non-competitive continuation RFP process to receive continued funding for the second and third contract year. Continued funding in future years is based upon the availability of funds and documented progress of the project(s) during the prior budget period. Due to fluctuations in federal funding levels, Title X and XX funding availability is subject to change for each contract year.

SECTION 5 TDH STAFF RESPONSIBILITIES FOR FAMILY PLANNING

The Texas Family Planning Division administers funds from three family planning funding sources (Title X: Family Planning, Title XIX: Medicaid, and Title XX: Social Services) in order to promote and support the delivery of family planning and related services across the state. Program staff is located in the Texas Department of Health's (TDH) central office in Austin and in five of TDH's eleven Public Health Regions (PHRs). Staff in the PHRs are called Regional Family Planning Specialists (RFPPSs), and each is the primary contract manager for provider agencies in their assigned PHR(s). Central office staff is organized by function: **administrative, clinical, and special projects.**

While roles and responsibilities of the staff often overlap (e.g., development of educational materials, provision of technical assistance, assessing provider agency performance), the following descriptions will help guide provider agencies and others to the appropriate source of information and assistance desired.

1. ADMINISTRATIVE SECTION — Primary Roles and Responsibilities:

Administer the program policies, procedures, and rules for the three family planning funding sources (Titles X, XIX, and XX).

Allocate funds, monitor contractor spending, adjust and amend contractor budgets as necessary.

Coordinate the funding application and contract renewal process for approximately 70 family planning agency contracts with approximately 350 clinic sites.

Oversee the automated claims processing and reporting systems.

Provide programmatic technical assistance to RFPPSs.

Coordinate and support the Family Planning Advisory Committee (FPAC) and the Subcommittee of Regional Coordinating Committee Chairpersons (SRCCC).

Develop special grant applications and special initiatives.

Analyze and track proposed legislation and regulations.

2. CLINICAL POLICY/EDUCATION SECTION — Primary Roles and Responsibilities:

Develop, review, and revise clinical policies for delivery of family planning services by agency contractors.

Provide, directly or in collaboration with the Center for Health Training, clinical technical assistance or training to family planning service providers.

Develop and disseminate newsletter for family planning service providers.

Develop and distribute family planning educational materials.

Serve as a resource for family planning clinical information.

Review and update Medicaid clinical policy with regard to family planning in collaboration with the Texas Health and Human Services Commission (HHSC).

Liaison with the TDH Quality Assurance Division for integration of program needs and site visit findings.

Coordinate state's Federal Region VI Infertility Prevention Project.

Coordinate state's Title X HIV Prevention Projects.

3. SPECIAL PROJECTS — Primary Roles and Responsibilities:

Administer Family Violence/Sexual Abuse Prevention Project.

Administer Male Involvement Initiative.

Administer Teen Pregnancy Prevention Workgroup.

4. REGIONAL FAMILY PLANNING PROGRAM SPECIALISTS (RFPPSs) — Primary Roles and Responsibilities:

Serve as primary liaison between the family planning agencies and the Texas Department of Health by:

- Interpreting program policies and procedures, ensuring correct implementation of new policies. Monitor for compliance.
- Managing provider agency contracts (e.g., budget tracking and monitoring, contract revision).
- Providing technical assistance and education to contractors.
- Promoting community relations with TDH and with other health and social services entities.
- Participating in Regional Coordinating Committee (RCC), Regional Health Education, and Family Planning Advisory Committee meetings.

Respond to inquiries from providers, community, and the public.

Assist providers in resolving claims processing issues.

Contribute to the contract application review and funding processes.

Conduct clinical and administrative site visits with the Quality Assurance Division's teams (includes development and follow-up of provider's corrective actions and providing technical assistance). Provide quality assurance feedback to contractors and to central office program staff.

Conduct site reviews for Medicaid Family Planning Agency applicants.

Serve as primary program liaison to various groups:

- Regional Health Departments
- Local Health Departments
- Family Planning Coordinating Committees
- Health and Social Service Agencies

Participate on special projects or work groups as requested by central office staff.

SECTION 6 PROVIDER SUPPORT TEAMS

The primary purpose of creating provider support teams is to facilitate orientation and on-site knowledge of contractors for Family Planning Division staff from the TDH central office. This enables them to more effectively serve in their capacity as program administrators, project managers, grant writers/developers, RFP application reviewers, and clinical or administrative consultants. The intent is to supplement/support the efforts of the RFPPS, rather than duplicate their responsibilities to contractors. While technical assistance may be offered when appropriate, the visits are not intended to monitor or assess the clinics or agencies.

Each Provider Support Team is composed of two or three central office staff and an RFPPS. They are formed to combine administrative and clinical expertise, newer staff with tenured staff, and to draw upon cultural competencies. These teams may be realigned as needed to accommodate staffing changes and workload.

SECTION 7 POLICY CLARIFICATION PROCEDURE

Background

The Policy Inquiry Process has been established to provide clarification to family planning contractors when questions regarding family planning policy arise. The goals of this process are to:

- Standardize the procedure used to answer contractors' policy questions
- Respond to inquiries in a timely manner
- Provide consistent information to all Regional Family Planning Program Specialist (RFPPS), Central Office Staff, and family planning contractors

What issues are considered candidates for the Policy Inquiry Process?

- An issue arising because of changes in laws, rules, technology, or medical practices
- An issue that affects many providers that has not yet been addressed in policy
- Conflicting family planning policies or requirements
- Informal understandings/instructions that have not been formalized into policy

An issue specific to only one or two providers would not go through the formal policy inquiry process.

Submitting a Policy Inquiry

The Regional Family Planning Program Specialist usually serves as the point of contact for contractors' policy questions. The RFPPS forwards pertinent question(s) to Central Office. On occasion, Central Office staff may be contacted directly by the agency for a policy clarification. Providers are encouraged, as much as possible, to route questions through their RFPPS.

What are the steps for RFPPS to submit a policy inquiry?

- Get questions from contractor
- Determine whether question is appropriate for policy inquiry process
- If yes, fill out form as completely and succinctly as possible
- Submit form to Central Office Policy Inquiry Coordinator

What are the steps when a policy question is received directly by Central Office staff?

- Determine if a policy clarification is required
- If yes, fill out a policy form. Attach any correspondence from the contractor

Central Office Procedures

- The Policy Inquiry Coordinator will review the form to ensure that the question is clear, has not been addressed previously, and would be best addressed through this process.
- If a policy clarification is not required, or if the issue has already been addressed, the Coordinator will provide pertinent information to RFPPS.

- If a policy inquiry is initialed, the Coordinator will forward it to either the clinical or the administrative section leads, as appropriate. Clinical/education questions will be referred to the administrative section lead. Administrative questions will be referred to the administrative section lead.
- The Policy inquiry will be copied to all RFPPS, to the lead of the other section, and to the FP Program Director.
- If RFPPS have any comments/suggestions about the policy inquiry, these should be directed to the appropriate section lead.

Answering a Family Planning Policy Inquiry

- Section lead assigns Policy Inquiry to staff.
- Assigned staff researches the issue and drafts a response.
- A draft is submitted to the appropriate section lead for review.
- A final draft is submitted to the Family Planning Program Director for final approval.
- The final version is signed off.

OR

- An internal memo or email is sent by the section lead or the designated staff to the submitter to let them know that the inquiry is being handled.
- A final response will be issued.
- Coordinator will notify all RFPPS and Central Office staff of the final decision.
- The final policy clarification will be filed in a binder at Central Office and on the common computer network directory.
- RFPPS will send the policy clarification out to contractors.

II CLIENT RIGHTS

SECTION 1 PROMPT SERVICE

Contractors are responsible for ensuring that family planning services are provided to clients promptly. It is the expectation of the Family Planning Division that clients be seen as soon as possible, with the goal of 30 days. Certain clients, such as teens, should be seen earlier, within two weeks of requesting services. Medicaid providers are required to see Medicaid clients within 30 days of the request for services.

§56.10. Prompt Service.

Medicaid clients requesting family planning assistance, must be offered services within 30 days of request.

SECTION 2 FREEDOM OF CHOICE

Family Planning clients are guaranteed the right to choose family planning providers and methods, as appropriate, without coercion. Medicaid clients are free to receive services from any Medicaid-enrolled family planning provider, even in Managed Care areas.

§56.11. Freedom of Choice.

Clients have the right to freely choose family planning methods and sources for services. Clients must not be subjected to any coercion to receive services.

SECTION 3 CONFIDENTIALITY

§56.12. Confidentiality

The department and providers must ensure the safeguarding of client family planning information. Clients must give written permission prior to the release of any personally identifying information except reports of child abuse required by Chapter 261 of the Texas Family Code, and as required or authorized by other law. The department may distribute appropriated funds only to contractors that show good faith efforts to comply with all child abuse reporting guidelines and requirements.

(1) The provider must ensure client confidentiality and provide safeguards for clients against the invasion of personal privacy.

(2) All personnel (both paid and volunteer) must be informed during orientation of the importance of keeping information about a client confidential.

(3) Client's records must be monitored to ensure access is limited to appropriate staff and to department staff or their authorized representatives.

(4) The client's preference of methods of follow-up contact must be documented in the client's record.

(5) Each client must receive verbal assurance of confidentiality and an explanation of what confidentiality means.

Providers must also comply with all state and federal laws regarding privacy of protected health information.

See the appendices for the most pertinent state child abuse reporting laws.

SECTION 4 NON-DISCRIMINATION

§56.16. Civil Rights. The department and providers must make family planning and genetic services available without regard to marital status, parenthood, handicap, age, color, religion, sex, ethnicity, or national origin. The provider must comply with Title VI of the Civil Rights Act of 1964 (Public Law 88-352); § 504 of the Rehabilitation Act of 1973 (Public Law 93-112); The Americans with Disabilities Act of 1990 (Public Law 101-336), including all amendments to each; and all regulations issued pursuant to these Acts.

SECTION 5 SERVICES TO ADOLESCENTS

§56.15. Family Planning for Adolescents.

(a) Adolescents age 17 and younger must be provided individualized family planning counseling and family planning medical services that meet their specific needs within 2 weeks of request.

(b) The provider must ensure that:

(1) counseling for adolescents encourages them to discuss their family planning needs with a parent, an adult family member, or other trusted adult;

(2) counseling for adolescents includes information on use of all medically approved birth control methods including abstinence;

(3) appointment schedules are flexible enough to accommodate access for adolescents requesting services;

(4) for the adolescent electing a non-prescriptive method, full participation in family planning medical services is encouraged but may be deferred by the client; and

(5) the adolescent is assured that all services are confidential and that any necessary follow-up contact will also protect the client's privacy.

It is important not to assume that adolescents are sexually active simply because they have come for family planning services.

Adolescents must be counseled, as age-appropriate, about resisting sexual coercion, and be assessed for potential child abuse.

SECTION 6 TERMINATION OF SERVICES

Under some circumstances, clients in Title XX only clinics may be denied services by contractors. If a client was determined to be capable of paying a full or reduced co-payment, but the client has not paid, they may be denied services. Clients also have the right to request a fair hearing.

Contractors must have board-approved policies and procedures in place regarding termination of services to clients. Before denying services to a client, contractors must send the client at least two notices that the payment is overdue. The second notice must be sent at least 30 days after the first notice. The method used to notify clients must safeguard their confidentiality. When sending the second notice, contractors must also send clients a notification of denial, reduction, or termination of services that informs them of their right to request a fair hearing. Agency providers must wait 10 days from the date on the notification letter before terminating the services. If clients were eligible and request a fair hearing within 10 days, services must continue. Documentation of the termination process must be kept in the client record.

SECTION 7 RESOLUTION OF GRIEVANCES

Contractors must ensure that family planning clients have the opportunity to express concerns about care received and to further ensure that those complaints are handled in a consistent manner.

Clients should be informed of and encouraged to lodge any complaints through appropriate channels during the initial intake.

The following information must be included on the complaint form:

- Client name
- Client phone number
- Client mailing address
- Name of the contractor
- Address where the incident occurred
- Date of the occurrence
- Names and titles, if applicable, of those implicated and/or providing service
- Names of those who were witnesses
- Actual complaint should be written in narrative form
- Name of the person who took the complaint
- Phone number of the person who took the complaint

The client should be assured by whoever is taking the complaint that their identity will be kept confidential. Only those TDH staff involved in the complaint process will have the client's identifying information.

Copies of all complaints will be directed to the Director of the Family Planning division.

All complaints will be referred to the appropriate Regional Family Planning Program Specialist (RFPPS) for further investigation.

RFPPS must maintain contact with the complainant.

The Director of the Family Planning division and the RFPPS are to plan what steps to take in investigating the complaint.

Once the plan is in place, the RFPPS is to call the contractor and inform them of the complaint. At that time if it is determined a visit is necessary, an appointment for a visit to the contractor's site is made.

The purpose of the visit will be to interview staff and if necessary other clients. At that time the RFPPS informs the contractor it is their opportunity to state their version of the incident. The RFPPS should gather information to help determine the validity of the complaint. This may include reviewing records, viewing the facility, interviewing staff and clients, etc.

RFPPS makes a written report to the Director of the Family Planning division. Discussion and consultation takes place between the Director of the Family Planning division and the RFPPS. Once adequate information has been gathered, an assessment is made.

The RFPPS and Director of the Family Planning division consult and develop a recommendation and justification for recommendation. RFPPS informs the complainant and the contractor of the recommendation.

If it is determined the report is valid the RFPPS and Director of the Family Planning division develop a corrective action plan for the contractor to follow and the contractor is monitored by the RFPPS.

A written report of the visit, the information, which has been gathered, and the assessment are maintained in the contractor file with an explanation as to the final determination and the date complainant was informed of outcome.

When appropriate, complaints will be referred to the Texas State Board of Social Work Examiners, the Texas Board of Nurse Examiners and/or Medicaid Program Integrity.

Substantiated complaints against a provider that recur or are not responded to with an appropriate corrective action plan will jeopardize a provider's continued participation.

Excessive complaints and/or lack of responsiveness to corrective actions will place a provider at higher risk for a QA visit. Sanctioning resulting from QA visits may jeopardize continued participation as a provider.

III CLIENT SERVICES

SECTION 1 CLIENT HEALTH RECORD

The contractor/provider must maintain a complete, legible, and accurate record of each client's health care, as follows:

All client records are arranged in a consistent chart order.

The client's record includes the following appropriate documentation:

- Client identification data
- Preferred language/method of communication
- Where and how to contact the client (to facilitate continuity of care and assure confidentiality)
- History (as detailed in History and Risk Assessment)
- Physical examination (as detailed in Medical Evaluation)
- Results of screening, findings of physical exam and other diagnostic tests
- Assessment/Provisional diagnosis
- Plan of care, including education/counseling, treatment and recommended subsequent visits and follow-up
- Referrals made and their outcome(s)
- Each entry signed and dated by the provider or designee
- Informed consent forms for services.
- All clients must provide signed and witnessed consent for family planning services initially.
- Clients must provide signed and witnessed consent for prescriptive contraceptive methods that are prescribed for the client.
- A consistent mechanism to prominently document and track health and social problems/issues to promote continuity of care, e.g. a problem list.
- Medication record
- Indirect encounters, e.g. phone calls

SECTION 2 HEALTH/SOCIAL HISTORY AND RISK ASSESSMENT

All clients must have a complete health and social history/risk assessment completed initially and updated at each subsequent visit.

The health history/risk assessment and social history/risk assessment includes the following:

The medical history/risk assessment:

- Chief complaint/Reason for visit
- Current history/Health status
- Significant past illness and hospitalizations
- Previous surgeries and biopsies, including results and dates
- Medications, including over the counter (OTC) as well as complementary and alternative medicines/treatments (CAM)
- Allergies, sensitivities or reactions to medicines or other substance(s)
- Family history
- Gynecological history
- Obstetrical history
- Sexual behavior history, including family planning practices and sexual orientation
- Mental health history, to include anxiety, depression and suicidal thoughts/gestures
- Dietary/nutrition assessment (including eating disorders)
- Immunization history/assessment
- Occupational hazards or environmental toxin exposure
- Physical activity assessment
- Partner history pertinent to health risks to client

The social history risk assessment:

- Home environment
- Use of tobacco/alcohol/street drugs
- Trauma/Family violence/abuse (physical, emotional or sexual abuse)
- Education
- Financial resources/insurance

SECTION 3 PHYSICAL EXAM

All initial and routine follow-up clients must be provided an appropriate physical exam according to the purpose of visit. The physical exam may be deferred if the client history does not reveal potential problems. The physical exam and related prevention services should not be deferred beyond 3 months after the initial visit, and in no case may be deferred beyond 6 months, unless in the clinician's judgment there is a compelling reason for extending the deferral. All deferrals, including the reason(s) for deferral, must be documented in the client record.

Initial Family Planning Visit

- Height measurement
- Weight measurement
- Blood pressure measurement
- Cardiovascular Assessment
- Clinical Breast exam
- Pelvic exam
- Other systems as indicated by history.

Scheduled/Annual follow-up visits:

- Height measurement
- Weight measurement
- Blood Pressure measurement
- Pelvic exam (optimal interval per clinical judgment)
- Other systems as indicated by history

SECTION 4 LABORATORY TESTS

All initial and routine follow-up family planning clients must be provided appropriate lab tests and interventions if indicated. Laboratory tests may be deferred until the physical exam is provided.

Initial laboratory tests and interventions

- Sexually transmitted disease testing as indicated by risk assessment, history, or physical (including Syphilis serology, Hepatitis B Antigen (HbsAg), HIV Gonorrhea, Chlamydia, Human Papilloma Virus), either on-site or by referral
- Pregnancy test as indicated by history or physical
- Rubella serology, if status not previously established and documented in chart
- TB skin test as indicated by risk assessment, history, or physical, either on-site or by referral
- Pap smear (or results obtained and documented in chart, if done within last year)
- Other lab as indicated by risk assessment, history and physical, either on-site or by referral

Scheduled/Routine laboratory and interventions

- Pap smear (optimal interval per clinical judgment, not to exceed three years)
- Pregnancy test as indicated by history/physical
- Other lab as indicated by history/assessment or physical

SECTION 5 EDUCATION AND COUNSELING SERVICES

All clients must be provided preventive education and counseling in the following areas based on client's history/risk assessment and need.

Sexuality/Sexual Behavior

- Contraceptive options for timing of pregnancy or avoidance of unwanted pregnancy (including risks/benefits of available methods, signs/symptoms of common complications and warning signs)
- Preconception/genetic counseling for desired pregnancy
- STD prevention/Safer sex practices
- Sexual function

Nutrition

- Healthy (balanced) diet/Limit dietary fat and cholesterol
- Folic acid supplementation
- Calcium intake

Other health promotion

- Immunizations
  - Tetanus-diphtheria (Td) booster every 10 years)
  - Hepatitis B (age <25, if not previously immunized)
  - Rubella (if not previously immunized)
- Dental hygiene/care
- Physical activity/exercise
- Protection from UV light

Violence prevention

- Family/domestic abuse (recognition and appropriate interventions)
- Resistance to sexual coercion for minors
- Gang behavior

Injury prevention

- Safe storage or removal of firearms
- Car safety lap/shoulder belts (Infant car seats to include installation and use)
- Bicycle/Motorcycle/ATV helmets
- Home safety (smoke detectors)

Substance abuse

- Avoid tobacco use/exposure
- Avoid underage alcohol use
- Avoid illicit drug use
- Avoid alcohol use while driving, swimming, boating, etc.

Other education based on specific problems or health risk.

Information about the range of available services and how to obtain services at any hour of the day.

SECTION 6 REFERRAL AND FOLLOW-UP

Agencies must have written policies and procedures for follow-up on referrals that are made as a result of abnormal physical examination or laboratory test findings. These policies must be sensitive to clients' concerns for confidentiality and privacy and must be in compliance with state or federal requirements for transfer of health information.

SECTION 7 METHODS OF FERTILITY REGULATION

§56.6 Range of Methods

All Federal Drug Administration (FDA) approved methods of contraception must be made available to the client, either directly or by referral to another provider of contraceptive services. All brands of the different contraceptive methods need not be made available, but each major contraceptive category must be made available.

Family planning agencies must offer on-site, at a minimum, the following methods of fertility regulation:

Sexual abstinence education and counseling

Barrier methods and spermicides

Oral contraceptives

Injectable contraceptives

Transdermal hormonal contraceptives

Vaginal hormonal contraceptives

Postcoital emergency contraceptive pills

Providers are encouraged to offer the full range of available contraceptive methods on-site, but lack of appropriate facilities or expertise may make it necessary to refer clients to another provider for some methods.

Sterilization procedures, when performed or arranged for by the family planning agency, must be in compliance with regulations for sterilization of persons in federally assisted family planning projects. (See Chapter IV, Section 5)

IV CLINIC OPERATIONS

SECTION 1 QUALITY ASSURANCE ACTIVITIES

The contractor/provider must develop and implement a plan for internal review and evaluation of its services to assure the provision of quality services and compliance with basic standards and policies.

The contractor/provider's plan will establish the frequency of internal review and evaluation.

The contractor/provider plan will identify individuals responsible for internal review and evaluation. The medical director must participate in quality assurance activities.

The contractor/provider's plan uses forms/tools to review and evaluate services.

The contractor/provider's plan includes the following areas for review and evaluation:

- administrative policies
- eligibility
- billing
- provision of clinical services with performances of all medical duties by staff defined by the medical director and approved based upon the medical director's or delegate's evaluation of the individual's education, experience, and clinical expertise through
- observation
    - record review
- physical facilities, e.g., safety and biohazard issues, accessibility, fire extinguishers, etc.
- client satisfaction survey annually
- clinic systems, e.g., client flow, appointments, etc.
- risk management system, e.g., adverse outcomes

The contractor/provider's plan will include:

- A report of findings and recommendations.
- An action plan to correct or improve services/systems.
- An evaluation of the action plan to ensure findings were corrected or improved.

SECTION 2 STAFF QUALIFICATIONS

The contractor/provider must hire personnel who meet minimum job qualifications, and the contractor/provider's medical care services must be provided under the supervision, direction, and responsibility of a qualified medical director.

The contractor/provider must ensure that clinical services are provided by properly educated and credentialed staff as documented by appropriate licensure, registration, certification, and/or experience for meeting job qualifications.

SECTION 3 STAFF DEVELOPMENT

The provider must have a documented plan of organized staff development based on an assessment of training needs, quality assurance indicators, and changing regulations/requirements, and must include orientation and in-service training for all personnel, including volunteers. There must be documentation of initial employee orientation and continuing education.

SECTION 4 PROTOCOLS, STANDING DELEGATION ORDERS, AND PROCEDURES

Family planning agencies must have written protocols, standing delegation orders (SDOs), and procedures for all clinical and educational services available at the agency.

- These protocols, SDOs, and procedures must be reviewed, approved, and signed by the agency medical director.
- Protocols and standing delegation orders for licensed health professionals must be developed and maintained in accordance with laws governing professional practice.
- All staff must receive orientation and training regarding the protocols, standing delegation orders, and procedures that pertain to their work responsibilities.
- There must be a complete copy of the clinical and educational protocols, standing delegation orders, and procedures at all clinic sites.

SECTION 5 CONSENT FOR SERVICES

The client's written informed voluntary consent to receive services must be obtained prior to the client receiving any clinical services. In addition, if a client chooses a prescription method of contraception, a method-specific consent form for the method chosen must be signed and updated as needed to reflect current information. If the client does not understand the language of the consent form, it must be interpreted. Consent information must be effectively communicated to every client, including those who have language barriers or who have disabilities that impair communication.

§56.14. Consent. The department and providers may provide family planning services, including prescription drugs, without the consent of the minor's parent, managing conservator, or guardian only as authorized by Chapter 32 of the Texas Family Code or by federal law or regulations. A provider may not require consent for family planning services from the spouse of a married client.

Title X projects may not require written consent of parents or guardians for the provision of services to minors, nor can the project notify parents or guardians before or after a minor has requested and received Title X family planning services.

The TDH designated consent form *(the same as the Medicaid Sterilization Consent Form)* is the only acceptable consent form for sterilizations funded by Title X or Title XX. In brief, the individual to be sterilized:

must be at least 21 years old at the time the consent is obtained;

must not be mentally incompetent;

must voluntarily give his or her informed consent;

must sign the consent form at least 30 days but not more than 180* days prior to the sterilization procedure;

may choose a witness to be present when the consent is obtained.

*An individual may consent to be sterilized at the time of premature delivery or emergency abdominal surgery, if at least 72 hours have passed after he or she gave informed consent to sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

The consent form must be signed and dated by:

the individual to be sterilized;

the interpreter, if one is provided;

the person who obtains the consent;

the physician who will perform the sterilization procedure.

Informed consent may not be obtained while the individual to be sterilized is:

in labor or childbirth;

seeking to obtain or obtaining an abortion;

under the influence of alcohol or other substances that affect the individual's state of awareness.

SECTION 6 SECURITY AND RETENTION OF CLIENT RECORDS

Client Records and Documentation Statement: The contractor/provider must have an organized client record system.

- The record is organized to facilitate retrieval and compilation of information.
- The record is readily accessible.
- The record is confidential and secure:
  1. Safeguarded against loss or use by unauthorized persons.
  2. Secured by lock when not in use or inaccessible to unauthorized persons.
  3. Maintained in a secure environment in the facility as well as during transfer between clinics and in between home and office visits.
- The record is available to the client upon request and with a signed release of information.

§56.9. Records Retention. Providers must maintain for the time period specified by the department all records pertaining to client services, contracts, and payments. Title XIX (Medicaid) record retention requirements are found in 1 Texas Administrative Code §354.1003 (relating to Retention of Records). The department contractors must follow contract provisions and the department's Retention Schedule for Medical Records. All records relating to services must be accessible for examination at any reasonable time to representatives of the department and as required by law.

Electronic records are acceptable as medical records.

SECTION 7 CLIENT ACCESS TO SERVICES AND ADDRESSING BARRIERS

The contractor/provider must ensure that clients are provided services in a timely and nondiscriminatory manner. It is the expectation of the Family Planning Division that clients be seen as soon as possible, with a goal of 30 days from initial request for most clients and two weeks for certain clients such as adolescents.

- The contractor/provider has a system to prioritize clients' needs.
- A policy is in place that delineates the timely provision of services.
- The contractor/provider complies with applicable civil rights statutes, regulations and guidelines, and nondiscrimination requirements.
- The contractor/provider has a triage system that utilizes qualified staff.
- The contractor/provider must comply with all applicable civil rights statutes, regulations and guidelines, and nondiscrimination requirements, such as the Civil Rights Acts of 1964 and 1991 and the Americans with Disabilities Act of 1990.

SECTION 8 EMERGENCY RESPONSIVENESS

The contractor/provider must be adequately prepared to handle emergency situations.

- Each site must have a written plan for the management of on-site medical emergencies, emergencies requiring ambulance services and hospital admission, and emergencies requiring evacuation of the premises.
- Each site where sterilization procedures are performed must have an arrangement with a licensed facility for emergency treatment of any surgical complication; and if sterilization procedures are performed in a freestanding surgical care center or an inpatient basis in a hospital, Medicare standards applicable to the facility and staff must be met.
- Evacuation plans for the premises must be posted.
- Each site must have staff trained in cardiopulmonary resuscitation (CPR) and emergency medical action. Staff trained in CPR must be present during all hours of clinic operation.
- Each site must maintain emergency resuscitative drugs, supplies, and equipment appropriate to the services provided at that site.

SECTION 9 COMMUNITY EDUCATION/OUTREACH

The provider must have a developed and implemented plan to provide community education to inform the public of its purpose, to disseminate basic family planning knowledge, to enlist community support, and to attract potential clients.

To inform the community of their services, the contractor/provider has a process that includes:

- Making information about contractor/provider services available to the public through various media.
- Translating public awareness materials into appropriate languages.
- Distributing information about its services to other organizations and agencies that deal with potential clients.

V PROGRAM ADMINISTRATION

SECTION 1 REQUIRED REPORTS FOR TITLE X

Financial Reporting

The Title X program operates using a "Total Budget Concept." This means that all funding programs that are included in the contractor's approved budget (Medicaid, Title XX, patient fees/co-pays, in-kind donations, other funds included in the budget) become part of the Title X project. All revenue directly generated by or earned as a result of the Title X project is considered program income. Title X contractors are required to identify and report receipt and expenditure of program income both quarterly and annually on the Financial Status Report (FSR) Form 269A. Program income generated under the Title X contract must be expended prior to receiving reimbursement for program costs from Title X. The quarterly reports are due 30 days following the end of the first, second, and third quarter of the contract year. The final FSR (269A) is due within 90 days following the end of the contract year/fourth quarter. TDH reserves the right to base funding levels, in part, upon the contractor's proficiency in identifying, billing, collecting, and reporting income, and in utilizing it for the delivery of family planning services. For more information on financial reporting, see the TDH Grants Management web page at http://www.tdh.state.tx.us/grants/default.htm

Programmatic Reporting

a. Client Encounter Data:

Although Title X contractors are not reimbursed on a fee-for-service basis, contractors are still required to submit encounter data for every client* served in a Title X clinics. Data is collected when the provider submits a 2017 form. These encounters are necessary to validate data submitted on the Family Planning Annual Report (see below) and for other reports that provide valuable data for measuring and projecting service utilization and analysis of trends. Contractors are responsible for maintaining statistical and management information systems that are compatible with accurate reporting of contract performance, i.e., unduplicated medical users, and tracking progress toward contract objectives. They also must submit a claim encounter form for all clients; if not billed to Title XX or Medicaid, the encounter must be submitted as Title X only. (See **c.** below**, Annual Progress Report**.)

* This applies to all clients who receive care in the clinic and whose services are paid for by one of the programs in the Title X budget. This would not include Title V, but would include XX, Medicaid, and self-pay clients.

b. Family Planning Annual Report (FPAR):

Aggregate client data is submitted annually by TDH to the Department of Health and Human Services (DHHS) Office of Population Affairs (OPA) on the **Family Planning Annual Report (FPAR).** Types of client data include age, race, ethnicity, gender, family income, and contraceptive methods. Contractor revenue data, number of medical encounters, and medical personnel time are also reported. Individual contractor data for the prior year is compiled into one statewide report and submitted every February. Previously, this data was calculated by providers and submitted to the TDH Family Planning Division. Due to the implementation of Compass 21, client data beginning with the 2002 report will be collected through the Compass 21 reporting function. However, contractors will still be responsible for submitting revenue and personnel data, and for verifying the number of unduplicated medical clients reported through Compass 21.

c. Annual Progress Report on Title X Objectives:

All contractors receiving Title X funds must complete an annual progress report on project objectives. The report is due 60 days after the end of the Title X contract period. In this report, providers detail progress toward achieving the objectives that were established in the contractor's application for funding. Also addressed are any challenges faced in meeting those objectives and any reasons why an objective was not met. (See appendices for the reporting format.)

SECTION 2 PROVIDER TO PROGRAM INPUT

a. Family Planning Advisory Committee

The Family Planning Advisory Committee (FPAC) is designed to provide advice to the Board of Health (BOH) and the Family Planning Program Staff about comprehensive family planning services by persons broadly representative of all significant elements of the population to be served, and by persons in the community knowledgeable about the needs for family planning services.

The (FPAC) shall be established per TAC, Title 25, Part 1, §56.4 for the purposes of:

discussing upcoming agenda items of the BOH that are relevant to the provision of family planning services,

identifying concerns to be brought before the BOH,

developing a comprehensive work plan to be reevaluated every two years,

providing advice to the Board of Health in the area of comprehensive family planning services,

providing advice to the program staff in the area of comprehensive family planning services,

participating in the development of the family planning program,

participating in the implementation of the family planning program, and

participating in the evaluation of the family planning program.

Important points to remember about FPAC operation include:

Members to the FPAC will be solicited by program staff when a vacancy occurs or 6 months before a member's term is due to expire

All members of the FPAC and any subcommittees are strongly encouraged to nominate individuals to serve on the FPAC

Bylaws for the conduct of FPAC meetings are established in rule (See §56.4)

Meetings of the FPAC are held in Austin on a quarterly basis

The FPAC may establish committees as necessary to assist the committee in carrying out its duties.

b. Regional Coordinating Chairpersons' Subcommittee

The Regional Coordinating Chairperson's Subcommittee was developed to ensure a statewide forum for provider and public participation in the development, implementation, and evaluation of the family planning program.

The Regional Coordinating Chairperson's Subcommittee (RCCS), consisting of the chairpersons of the Regional Coordinating Committees (RCC), shall be established for the purposes of:

discussing upcoming agenda items of the FPAC,

exchanging information about statewide programs,

attempting to resolve statewide provider concerns, and

identifying concerns to be brought before the FPAC.

Important points to remember about RCCS operation include:

Each chairperson of an RCC is expected to participate in meetings of the RCCS.

Bylaws for the conduct of RCCS meetings are established in rule. (See §56.4).

RCCS meetings are held in Austin on a quarterly basis.

The presiding officer of the RCCS is a member of the FPAC and will report issues from all of the RCC's at the meetings of the FPAC.

The method for providing feedback or resolving issues related to the family planning program at a statewide level is as follows:

- As issues from the RCCS are presented to the FPAC, a member of the FPAC may offer a motion for placement of an item on the agenda for the next meeting of the FPAC if it appears to be a concern that requires attention of the committee. If a particular item is anticipated to require action of the FPAC, then it should be noted as such so that the item may be placed on the agenda as an action item.
- If the motion is seconded and carries, it will be placed on the next agenda for the meeting of the FPAC as an item for discussion or as an action item.

c. Regional Coordinating Chairpersons Committee

The purpose of the Regional Coordinating Committees (RCC) are to ensure a regional forum for provider and public participation in the development, implementation, and evaluation of the family planning program.

A Regional Coordinating Committee (RCC) shall be established in each Public Health Region (PHR) consisting of representatives from family planning program contracting agencies for the purpose of:

discussing upcoming agendas items of the RCCS and the FPAC,

exchanging information about regional programs,

attempting to resolve regional provider concerns, and

identifying concerns to be brought before the RCCC.

Important points to remember about RCC operation include:

All contracting agencies are strongly encouraged to participate in the RCC in their PHR by selecting at least one representative from each clinic location to participate in meetings.

RCC's shall have established bylaws for their conduct through the RCCS. Copies of these bylaws may be requested from the TDH Family Planning Division or downloaded from the website.

Meetings may be conducted in person, by conference call, or through e-mail by copying all members of the RCC.

Each RCC shall select a chairperson.

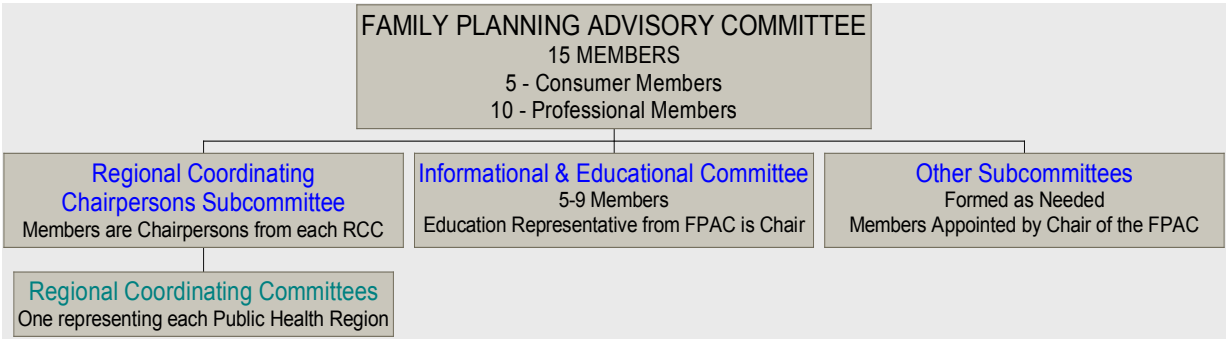
The method for providing feedback or resolving issues related to the family planning program at a statewide level is as follows:

Regional Family Planning Program Specialist (RFPPS) are the first point of contact.

Any questions or issue that cannot be resolved through an RFPPS should be brought to the attention of the RCC in the PHR of the contracting agency through the agency RCC designee(s).

The chairperson of each RCC is responsible for reporting those issues brought forward at the RCCS meeting.

Chart of Committees' Structure and Organization:



SECTION 3 COMMUNITY TO PROVIDER INPUT

a. Informational and Educational Committee

An Informational and Educational Subcommittee (I & E) is established to ensure that all contractors that receive Title X are in compliance with federal guidelines for family planning informational and educational materials.

All Family Planning contractors that receive Title X funds are required to maintain an I & E to review informational and educational materials that are distributed by the contractor to clients and/or the community.

Important points to remember about I & E operation include:

TDH and each Title X contracting agency will maintain an I & E Committee of 5 – 9 members who are broadly representative of the community.

Committees must review and approve all informational and educational materials developed or made available under the project prior to their distribution to assure that the materials are suitable for the population and community for which they are intended and to assure their consistency with the purposes of Title X.

Committees must review the content of the material to assure that the information is factually correct. The committee may delegate responsibility for the review of the factual, technical, and clinical accuracy to appropriate project staff. However, final approval of the informational and educational material rests with the committee.

Each I & E Committee must keep written records of the committee activities, with documentation of its determinations.

The chair of the FPAC shall appoint an I & E Committee to review and approve Title X material that are created and distributed by TDH Family Planning Division.

Materials that have been reviewed and approved by the TDH Family Planning Division I & E Committee must still be reviewed and approved by each Title X contractor agency's I & E Committee, since community cultures and standards vary across the state.

The chair of the TDH Family Planning Division I & E Committee is required to report committee activities to the FPAC.

TDH Family Planning Division I & E Committee members will sign a memorandum of acceptance agreeing to serve for a two year period.

An I & E Committee may meet as a group at a specific time and location, or the members may discuss the materials and their recommendations in a conference telephone call format.

There is no minimum number of meetings of an I & E Committee per year. The committee must review and approve all informational and educational materials before distribution by the agency, therefore meetings will occur as new materials come under consideration or on a regular basis according to individual agency policy.

TDH Family Planning Division I & E Committee will meet as new materials come under consideration.

TDH Family Planning Division has developed a review form and has a readability formula available for use by I & E Committees. These may be requested from the Family Planning Division or downloaded from the Family Planning Division website. I & E Committees are not required to use these forms or formulas for their evaluations, but

may develop their own standards for reviewing informational and educational materials if so desired.

b. Needs Assessment

Needs Assessments are performed to ensure that the provision of family planning services are based upon community needs and to ensure that all entities that request Title X funding for family planning services are in compliance with federal guidelines for making application for funding.

An assessment of the need for family planning services must be conducted prior to applying for a competitive grant award.

Important points in performing needs assessments include:

Agencies will determine community needs based on data collected through community assessments.

Data sources for community needs assessments may include:

- Written community needs assessments,
- Public surveys, or
- Minutes from community meetings.

The needs assessment documents the need for family planning services for persons in the service area and should include:

- Description of the geographic area including a discussion of potential geographic, topographic, and other related barriers to service,
- Demographic description of the service area including objective data pertaining to individuals in need of family planning services, maternal and infant morbidity/mortality rates, birth rates and rates of unintended pregnancies by age groups, poverty status of the populations to be served, cultural and linguistic barriers to services, etc.,
- Description of existing services and need for additional family planning services to meet community/cultural needs,
- Need indicators that include rates of STDs and HIV prevalence (including perinatal infection rates) in the grantee area,
- Identification and descriptions of linkages with other resources related to reproductive health, and
- Identification and discussion of high priority populations and target areas.

Findings of needs assessments should be shared with the local government and the community. It is recommended to document the sharing of this information.

As a part of being aware of community needs, each family planning agency is strongly encouraged to participate in coalitions and partnerships with other community organizations.

Grantees should perform and document periodic reassessment of service needs. Review and updating of data should occur at least every two years.

Competitive grant applications are required to include a full and updated needs assessment.

SECTION 4 CONTRACTOR PURCHASING RESPONSIBILITIES

a. Laboratory Services

All Title X and XX contractors must negotiate contracts and/or agreements with the lab(s) of their choice, which may include the TDH labs. Any labwork submitted by Title X or XX contractors to the TDH labs will be billed to the contractor.

Laboratory needs for contractors serving family planning clients can be met in a timely and cost effective manner at the TDH Bureau of Laboratories and/or the Women's Health Laboratory. Both laboratories offer a wide array of high-quality lab services at competitive prices. Any Title XX or X Family Planning Agency wishing to continue or establish an ongoing service agreement with one of the TDH laboratories should contact the laboratories directly. Rate information and lists of available tests can be requested directly from the TDH labs noted below:

Kathleen Allen, MBA, CT (ASCP)

-OR-

Alice Felux, Customer Relations

Women's Health Laboratories
Texas Center for Infectious Disease
2303 S. E. Military
San Antonio, Texas 78223
Phone: (210) 534-8857, Ext. 2357

CAP No: 21401-02, CLIA No. 45D0911298

Kathleen.allen@tdh.state.tx.us

Mary Spears

Bureau of Laboratories
Texas Department of Health
1100 W. 49th Street
Austin, Texas 78756
Phone: (512) 458-7111, Ext. 2658

CLIA No: 45D0660644

Mary.spears@tdh.state.tx.us

b. Pharmaceutical Supplies

All Title X and Title XX contractors are responsible for negotiating the purchase of pharmaceuticals and clinic supplies directly through their own resources. The information below describes sources that assist family planning agencies to obtain bulk purchase or discounted pricing.

Public Health Services (PHS) Pricing

In 1992, Public Law 102-585 (the Veterans Health Care Act) was signed into law. Section 602 of the Veterans Health Care Act enacted Section 340B of the Public Health Services Act, requiring a manufacturer who sells drugs to charge a discounted price for covered outpatient drugs to eligible entities. This is often referred to as "PHS pricing" or "340B pricing". Covered entities are certain grantees of the Public Health Service and some "disproportionate share" hospitals. Title X Family Planning grantees are eligible for the discount.

The federal Office of Pharmacy Affairs maintains a listing of individual eligible entities. The TDH Family Planning Division regularly sends a list of all the Texas Title X Family Planning agencies to the Office of Population Affairs, which then provides the information to the Office of Pharmacy Affairs so that their list can be updated. If any agency is a new Title X recipient, there may be a delay between the time TDH sends the updated list and the time the changes are made on the Office of Pharmacy Affairs list. To view a listing of eligible clinics, go to http://www.bphc.hrsa.gov/opa/sitemap.htm. If a Texas Title X Contractor encounters difficulty in obtaining the PHS discount from a pharmaceutical manufacturer, contact the TDH Family Planning Division.

Texas Building and Procurement Commission (TBPC)

The TBPC Cooperative Purchasing Program (TBPC Co-Op) offers a large selection of supplies (not just medical supplies) that have already been competitively bid. The TDH Family Planning contractors are eligible for membership in the TBPC Co-Op under the category of Assistance Organizations. To become members, contractors must submit a registration application and supporting documents to the TBPC. Members use the TBPC Co-Op by sending a requisition to the TBPC. The TBPC then sends a purchase order to the vendor, who ships the merchandise and the invoice directly to the member agency. If an item is not on state contract, members may suggest that it be added.

For more information about services and membership application, go to the Texas Building and Procurement Commission website at http://www.gsc.state.tx.us/stpurch/coopmain.html or phone (512) 463-3368. The catalog of supplies available through state contract is on-line at their website. To see the contraceptives available on state contract go to: http://www.gsc.state.tx.us/cat_page/cat_272_a1_0105.html. Please note that some items are listed at two different costs--one for agencies eligible for PHS discounts and one for other agencies. The PHS price will usually be significantly lower than the non-PHS price. As noted above, the PHS price is available only to agencies that receive Title X funds or are otherwise eligible.

The Family Planning Cooperative Purchasing Program (FPCPP) or The Cooperative Purchasing Network

The Family Planning Cooperative Purchasing *Program* has been operational for a number of years and assists Title X funded family planning agencies to make purchases without requiring a participation fee. The Cooperative Purchasing *Network* was established more recently and is available, for an annual membership fee, to non-profit licensed clinics that do *not* receive Title X. Both co-ops are operated by the California Family Health Council. For information, go to the FPCPP website at http://www.fpcpp.org/ or phone (213) 386-5614 ext. 4560.

SECTION 5 SUBCONTRACTING

Contractors must notify the Family Planning Division prior to entering into subrecipient agreements for the provision of family planning services. The application for funding should contain information on the services that will be subcontracted. For agreements put into place after the application was turned in, the provider should notify the Family Planning Division. If a contractor elects to contract out a substantial portion (as defined in the general provisions of the contract) of their services, **prior written approval** must be obtained from the TDH Director of Family Planning. Contractors are responsible for performing quality assurance reviews of all subcontracted clinic sites.

Contractors must have formal agreements or subrecipient agreements for direct client services that the contractors do not deliver. Subrecipient and other formal agreements must be written and are subject to the requirements of the contract. Subrecipient agreements must be executed on an annual basis and include:

- name, address, and signatures of all parties;
- well defined scope of work;
- rate and method of payment;
- clearly defined and executable termination clause;
- quality assurance.

VI DETERMINING CLIENT ELIGIBILITY FOR SERVICES AND ASSESSMENT OF CO-PAYMENT

SECTION 1 GENERAL GUIDELINES

All contractors receiving federal and state funding for the purpose of supporting subsidized family planning services must adhere to the guidelines for client eligibility and co-payment assessment and collection as set out by federal and state regulations and this Policy.

Note: For complete information regarding eligibility for Title V see the Title V manual. Eligibility for Medicaid is determined by Texas Department of Human Services.

Client eligibility for Titles X and XX is assessed by the contractor/delegate, using the Family Planning 2025 Eligibility Form or a program-approved substitute. The completed 2025 should be maintained in the client record, indicating at what poverty level the client fell and the % co-payment they will be charged.

Clients who are potentially eligible for Medicaid should be referred to the local Department of Human Services office for formal Medicaid eligibility determination.

Generally, income, residency, and family size are self-declared. Contractors may verify eligibility information from an applicant only if policies regarding proof of eligibility are documented and are applied uniformly to all applicants, or if verification of eligibility does not jeopardize the client's right to confidentiality. Contractors must re-determine eligibility at least annually, and when the client informs them of changes which might affect her or his eligibility.

- Title XX is limited to Texas residents;
- Title X is not limited to Texas residents.

For the purposes of determining eligibility, the following definitions will be used:

Family:

Family means a social unit composed of one person, or two or more persons living together, as a household.

Income:

All income received must be included. Income is calculated before taxes (gross). For individuals who are married or who are 20 years of age or older, the income of all family members must be used.

For unemancipated, unmarried individuals age 19 or younger, only the individual's income is used to assess eligibility, not the income of other family members. The adolescent's own income is applied to the size of the family as recorded on the eligibility form.

To calculate monthly income:

If income is received in lump sums or at longer intervals than monthly, such as seasonal employment, the income is prorated over the period of time the income is expected to cover. Weekly income is multiplied by 4.33. Income received every 2 weeks is multiplied by 2.165. Income received twice monthly is multiplied by 2.

The following are considered income for eligibility determination:

1) **Money, wages, or salary** includes earnings of children at least 14 years old, wages or salary received for work performed as an employee, including wages, salary, armed forces pay (include allotments from any armed forces received by a family group from a person not living in the household), commissions, tips, piece-rate payments, and cash bonuses earned. Overtime pay is estimated based on the person's history of receiving this pay.
2) **Net income from non-farm self-employment** includes gross receipts minus business expenses from one's own business, professional enterprise, or partnership, which result in the individual's net income.
3) **Net income from farm self-employment** includes gross receipts minus operating expenses from operation of a farm by the client or the client and his partners. Gross receipts include the value of products sold, government crop loans, and incidental receipts from the sale of wood, sand, mineral royalties, gravel, and similar items.
4) **Social Security and railroad retirement benefits** include Social Security pensions and survivor's benefits, permanent disability insurance payments made by the Social Security Administration (before deductions for medical insurance), and railroad retirement insurance checks from the federal government. Gross benefits from these sources are the amounts before deductions for Medicare insurance.
5) **Dividends and interest** include dividends from stock-holdings or membership in associations, interest on savings or bonds, and periodic receipts from estates or trust funds, and net royalties. These earnings are averaged for a 12-month period.
6) **Net income from rental of a house, homestead, store, or other property** includes net income from rental property, which is calculated by prorating and subtracting from gross receipts property taxes, insurance payments, bills for repair and upkeep of property, and interest on mortgage payments on the property. Capital expenditures and depreciation are not deductible.
7) **Income from mortgages or contracts** includes income the buyer promises to pay in fixed amounts over a period of time until the principle of the note is paid.
8) **Public assistance or welfare payments** include AFDC, refugee assistance, SSI, general assistance (cash payments from a county or city).
9) **Pensions, annuities, and irrevocable trust funds** include pensions or retirement benefits paid to a retired person or his survivors by a former employer or by a union, either directly or through an insurance company. Periodic payments from annuities, insurance, or irrevocable trust funds are also included.
10) **Veterans' pensions, compensation checks, and G.I. Benefits** include money paid periodically by the Veterans Administration to disabled members of the armed forces or to survivors of deceased veterans, subsistence allowances paid to veterans for education and on-the-job training and refunds paid to ex-servicemen as G.I. insurance premiums. (Include only that part of the educational allowance that is used for current living costs.)
11) **Educational loans, grants** include money received as scholarships by students for educational purposes. (Include only that part actually used for current living costs.)
12) **Unemployment compensation** includes compensation received from government unemployment insurance agencies or private companies during periods of unemployment, and any benefits to strikers received from union funds.

13) **Worker's compensation and disability payments** include compensation received periodically from private or public insurance companies for injuries incurred at work.

14) **Alimony** is a support payment to a divorced person by a former spouse.

15) **Child support** includes court-ordered child support, any maintenance or allowance used for current living costs provided by parents to a minor child who is a student, or any informal child support payments made by an absent parent for the maintenance of a minor child.

16) **Regular cash support payments from friends or relatives received on a periodic basis more than three times a year.**

17) **Net income from the client's share of an inheritance.**

18) **Foster Care Payments** include payments made to a household on behalf of a legally assigned foster child or foster adult.

19) **Capital gains from sale of property.**

Note: Income not described in items 1 through 19 is excluded in determining monthly gross income.

SECTION 2 TITLE X ELIGIBILITY

Contractors receiving both Titles X and XX funds and using them in the same site should note that Title X regulations always supersede Title XX eligibility and co-payment guidelines.

An eligibility assessment must be done of all clients who present for services at a clinic supported by Title X. If the client has a Medicaid card, this documents their Medicaid eligibility. For all other clients, the 2025 Title X/XX eligibility form is used to determine at which Federal Poverty Level (FPL) they fall. Subsidized services must be made available to client's up to 250% of the current FPL or higher if need is demonstrated. Clients are eligible regardless of residency. Eligibility must be assessed on an annual basis, or when the client's family size or income changes.

Co-payment:

Note: Clients must not be denied services due to inability to pay.

Each contractor must have an approved sliding fee scale in place for the purpose of determining co-payment. Contractor policies and procedures regarding co-payment collection must be approved by the agency's board. The sliding fee scale must be updated annually when the revised Federal Poverty Income Guidelines are released. This updated scale must then be submitted to the RFPPS for review and approval.

The Title X Guidelines, Section 6.3, require that "A schedule of discounts must be developed and implemented with sufficient proportional increments so that inability to pay is never a barrier to service. A schedule of discounts is required for individuals with family incomes between 101% and 250% of the Federal poverty level. Fees must be waived for individuals with family incomes above this amount who, as determined by the service site project director, are unable, for good cause, to pay for family planning services." Contractors must not charge a co-payment to individuals whose income and family size place them at or below 100% of the FPL, or to Medicaid clients. Above 100% FPL, client must be charged according to the approved sliding fee scale. Title X regulations state that co-pay MUST be assessed (unless the individual has been exempted for a documented reason), based on a sliding fee scale, of clients who fall between 101% and 250% of the current FPL scale. It doesn't matter if the client is eligible for XX; they must be charged co-payment (unless they've been exempted). Title XX does not allow co-pay to go over 25% of the total cost of services, so, co-pay for clients between 101% and 150% cannot exceed 25%.

"Title X Guidelines (section 6.3) require that charges be based on a cost analysis of all services provided by the project. At the time of services, clients who are responsible for paying any fee for their services must be given bills directly.

SECTION 3 TITLE XX ELIGIBILITY (FOR TITLE XX-ONLY CLINICS)

An eligibility assessment must be done of all clients who present requesting subsidized services at a clinic supported by Title XX. Using the 2025 eligibility form, client income and family size are used to determine at which Federal Poverty Level they fall. Subsidized services must be made available to client's up to 150 % of the current FPL. Clients must be Texas residents. Eligibility must be assessed on an annual basis, or when the client's family size or income changes.

Note: Outreach and sexuality education through group presentation and discussion for adolescents is available without regard to income.

Co-payment:

Contractors may assess a co-payment from clients; however, if the agency is to do so, they must have a board-approved policy in place that is applied to all clients, and is not a barrier to service. Co-payment for Title XX services may not exceed 25% of the authorized reimbursement amount for allowed services. Contractors must not charge a co-payment to any Title XX client with zero income.

Contractors who do assess co-pay may decide to waive co-payment for unmarried clients age 19 and younger. This must be documented in policy and procedure. Those providers who do not waive co-pay for these clients must not deny them family planning services if they cannot pay (due to lack of funds or concerns about confidentiality).

The contractor's board or advisory group must establish a policy about waiving or reducing client co-payments on an individual basis. Criteria must be established to determine the need to waive or reduce co-payments based on the circumstances of the individual Title XX client.

Contractors collecting co-payment must have a board-approved sliding scale co-payment schedule with at least two levels; 0% co-pay of the reimbursement amount and 25% of the reimbursement amount, or any reasonable variation within this range. These co-payment schedules must be revised annually when the Federal Poverty Income Guidelines are released. The updated fee scale must be submitted to the RFPPS for review and approval.

Client co-payments collected by the contractor must be used for the delivery of family planning services. This can be through purchase of equipment and supplies, or to provide additional subsidized family planning services.

VII CONTRACTOR REIMBURSEMENT FOR SERVICES

SECTION 1 TITLE X REIMBURSEMENT PROCESS

Agencies providing Title X family planning services are reimbursed for operational costs incurred during the contract period. Costs are assessed against the eight-category budget that was submitted and approved during the contracting process. Program Income must be expended before Title X funds are requested, so if Program Income equals or exceeds program expenses, Title X would not be billed. Once program expenses exceed Program Income, contractors bill Title X on a monthly basis. To request reimbursement, contractors submit a State of Texas Purchase Voucher (TDH Form B-13), and a Supporting Schedule for Title X Reimbursement Vouchers (Form B-13X). Reimbursement requests should be submitted monthly within 30 days following the end of the month in which the costs were incurred.

Contractors submit a final billing within 90 days following the end of the contract term.

Although Title X is not reimbursed on a fee-for-service basis, client encounter information must be submitted for each client in a Title X clinic that is part of the agency's Title X project. If a client is not eligible for Title XX or Medicaid, an encounter form must be submitted for reporting purposes to Compass 21.

Please contact Grants Management Division with any questions related to the required reporting formats or procedures.

Throughout the year, contractors may shift up to 10% of their total Title X budget between categories without prior approval. If this amount being shifted is greater than 10% or $25,000, the contractor must received prior approval from the Family Planning Division. Contractors are required to submit a revised budget for review, along with an explanation for the revised change.

SECTION 2 TITLE XX REIMBURSEMENT PROCESS

Providers are reimbursed for valid services provided to eligible clients. Payment is requested via claims submitted to Compass 21 for processing. Providers are reimbursed on a fee-for-service basis.

Claims filing deadlines are 120 days for new claims, 180 days for appeals. All claims and appeals must be submitted and processed within 90 days after the end of the contract period.

In order to receive reimbursement through Compass 21, providers must be enrolled with the Medicaid program, and have a Texas Provider Identifier (TPI) for billing. Title X and XX providers must enroll each clinic site with its own unique TPI that identifies that site. For details on enrolling clinics in the Medicaid program and for billing specifications, please see the Texas Medicaid Provider Manual.

Title XX provides reimbursement for a selected range of family planning services. Please see the most current Medicaid manual and any subsequent Medicaid bulletins for the latest information on covered services and allowable reimbursement.

SECTION 3 COMPASS 21

Enrollment:

All Title X/XX contractors must be enrolled with the Texas Medicaid program. A seven-digit Texas Provider Identifier (TPI) base number is assigned by the state Medicaid program to each agency. Each clinic site under that agency that also provides Family Planning services must enroll with the Medicaid program and be assigned a unique two-digit suffix to the base TPI. This number allows for the identification of activities at that clinic and provides the capabilities required for state and federal reporting, as well as accurate provider-level data for tracking purposes.

When a new clinic is opened and provides Family Planning services, the agency must request permission from the Director of the Family Planning Division to expand Family Planning services to that site, provide the reason for the expansion, and show how the expansion of services will be paid for under the existing contract. Next, the agency must submit a Medicaid enrollment application to the Texas Medicaid program in order to enroll the new clinic site.

The NHIC web page http://www.eds-nhic.com/provenrl.htm provides copies of the enrollment application forms.

Family Planning agencies are not required to enroll as Physician groups, which would entail the application for Performing Provider Numbers. To enroll as a Family Planning Agency, all that is required is a supervisory practitioner. This person may be a Doctor or Nurse Practitioner, and it may be the same person for all the clinic sites. If this person changes, the Medicaid program must be notified in writing, and the paperwork submitted to replace the supervisory practitioner.

When enrolling with the Medicaid program, Clinical Laboratory Improvement Amendments (CLIA) information must be provided. For public health agencies that provide limited numbers of tests, one CLIA certificate is all that is required for all the clinics; each clinic does not need its own CLIA certificate.

Provider Relations staff are available in each region to help you complete the applications accurately. They may be reached by contacting **NHIC's Customer Services hotline at 1-800-925-9126.**

All clinic site enrollment documents should be sent to

National Heritage Insurance Company
Provider Enrollment
12545 Riata Vista Circle
Austin, TX 78727-6524

Filing Claims/Encounters:

There are specific criteria that must be followed when submitting claims and encounters to Compass 21. Please review the instructions to the 2017 claim form to determine what fields must be completed with which values. For providers who use their own software (not TDH Connect) to submit billing claims, one claim in a batch with missing or invalid data will cause the entire batch to reject. All fields must contain valid information. When no Social Security number is available for a client, an established dummy number must be used. Always use 000-00-0001 when submitting claims for individual clients who do not provide a Social Security Number.

SECTION 4 STERILIZATION BILLING/REPORTING

When billing or submitting a Title X encounter form for a vasectomy or tubal ligation, all consent requirements must be followed or the claim cannot be paid. The reimbursement amount covers all costs associated with the procedure – office visits, lab tests, surgery costs, anesthesia, etc. If the reimbursement amount is not sufficient to cover all costs, the client may not be asked to pay for costs above the reimbursement rate. Client co-pays for sterilizations must follow the agency's established co-pay policy and may not exceed the allowable amount.

A valid consent form is always required in order to bill/report a sterilization (vasectomy or tubal ligation). Please see "Consent" section of this manual for greater detail. Consent forms must be received by Compass 21 prior to the processing of sterilization claims. When a claim arrives at NHIC, it is processed immediately, while the consent form must be manually entered. When the claim is processed, a search is done for the corresponding consent form. The claim will reject if the consent is not found in NHIC's system. In order to prevent this scenario from occurring, please follow these steps:

1. FAX all consent forms to NHIC at **512-514-4229.**
2. **Wait 2-3 days** before sending in the corresponding claims, whether they are sent on paper or electronically. (Copies of the related consent form may be included with each claim for paper billers, but will not be used in lieu of the faxed consent form.)

Note: Consents remain valid in the *Compass 21* system for 180 days.

Consent forms for Title V, X or XX sterilizations must indicate that the client is non-Medicaid. This can be written on the form itself (not on the fax cover sheet) or "non-Title XIX" can be noted in the box in the lower right corner of the consent form.

Sterilizations must be billed with Type of Service (TOS) "1". If they are billed with TOS "2", the claim will deny. TOS "2" is used when billing for surgeries only. Since Title V and Title XX sterilizations are paid as a global fee, which includes all costs associated with the surgery (office visit, lab tests, physician fees, hospital costs, anesthesiology, etc), it cannot be billed as TOS "2".

Claims must contain the appropriate sterilization diagnosis code and use appropriate procedure codes. See Texas Medicaid Provider Procedures Manual.

Claims for incomplete sterilizations are submitted to NHIC with appropriate diagnosis code. Providers may bill for charges incurred up to total allowable reimbursement rate for sterilizations. Justification and billing detail are no longer submitted with claim, but must be available in client file. RFPPS will review documentation during site reviews.

Duplicate claims:

Occasionally, duplicate claims make it into the system. Duplicate claims will show up on the Remittance and Status Report as denied with EOB 00127. This EOB will provide the date and claim number of the previous claim payment. A date of **Ø** and ICN of **Ø** indicate that the duplicate claim can be found on the same R&S report as the claim that was paid.

SECTION 5 RETRO-ELIGIBILITY FOR ALL FUNDING SOURCES OTHER THAN TITLE X

Current Medicaid rules allow Medicaid (Title XIX) to pay for medical costs incurred by a client within the 90 days prior to her or his eligibility date. This means a client's services may have been billed to and paid for under Titles V or XX (payment to the provider), or an encounter form may have been submitted for Title X, during that 90-day period prior to the client's determination as Medicaid-eligible. Once a client becomes Medicaid-eligible, NHIC searches Titles V, X, and XX claim/encounter history for claims/encounters approved for that client within the prior 90-day period. When NHIC determines that services were paid under V or XX for that client, the previously paid claim will be adjusted so that the V or XX funds are returned to the provider. If the services were approved as a Title X encounter, that encounter will be adjusted. The claim will then be billed to Medicaid, resulting in savings for the Title V, X, or XX programs.

When this happens, providers will see the following:

Titles V and XX Claims

On the Title V or XX R&S report, in the "Adjustments — Paid or Denied" section, the original claim will show as an adjustment with EOB 06051 — *Recoupment is due to Title XIX retro-eligibility*. This action sets up a recoupment for the amount approved, so it will be taken out of any other payments that week or out of any future payments. Since Medicaid does not allow providers to collect co-payments, providers must reimburse the client if any co-payment was collected.

If the client participates in traditional fee-for-service Medicaid, and the claim is finalized (paid or denied), the adjusted claim will appear on the Title XIX FP R&S report for the same week the original claim appears as an adjustment on the Title V or XX R&S report. The adjusted claim will show as billed and paid to Medicaid. If the client is enrolled in Medicaid Managed Care, the claim will show as denied on the Title XIX FP R&S report with EOB 00081 - *Claim billed to NHIC in error. Bill HMO. If client is a STAR+PLUS MQMB file appeal to NHIC*. Providers will need to submit these claims to the correct Medicaid Managed Care Organization.

Title X Encounters

If the claim was submitted as a Title X encounter, it will show up on the Title X R&S report as an adjustment with EOB 6051 — *Recoupment is due to Title XIX retro-eligibility*; since Title X encounters are not paid, a recoupment will not be set up. Providers will be required to reimburse the client for any co-pay collected.

If the client participates in traditional fee-for-service Medicaid, and the claim is finalized (paid or denied), the adjusted claim will appear on the Title XIX FP R&S report for the same week the original claim appears as an adjustment on the Title X R&S report. The adjusted claim will show as billed and paid to Medicaid. If the client is enrolled in Medicaid Managed Care, the claim will show as denied on the Title XIX FP R&S report with EOB 00081 - *Claim billed to NHIC in error. Bill HMO. If client is a STAR+PLUS MQMB file appeal to NHIC*. Providers will need to submit these claims to the correct Medicaid Managed Care Organization.

Lab Tests

Since Medicaid does not allow providers to bill for laboratory tests for which they are not CLIA certified, any lab tests from a Title V, X or XX claim/encounter that aren't allowable for the provider under Medicaid rules will show up on the Medicaid FP R&S report as denied, with an EOB of 00488 — *Our records indicate that there is no CLIA number on file for this provider number or the CLIA is not valid for the dates of services on the claim*.

Unless providers establish a process with their contracted laboratories for handling retro-eligibility, providers will not be properly reimbursed for all lab tests. When the full amount of the original claim/encounter is backed out of V, X or XX, it will include payment for all laboratory tests provided to the client. The provider will have already paid the contracted laboratory for those tests. When the claim is re-processed as a Medicaid claim, providers will not receive payment for lab tests for which they are not CLIA certified.

Providers will need to notify their contracted laboratory when these claims are identified so that the laboratory can reimburse the provider or set up an accounts receivable for any previously paid tests, and then submit a Medicaid claim for those tests to NHIC. For claims past the 95-day filing deadline, the laboratory will be required to follow the standard Medicaid appeals process. NHIC and HHSC are investigating an alternate process for these claims.

SECTION 6 CLAIMS RELATED TO COMPLICATIONS

Claims for complications related to IUDs, implants, or sterilizations are submitted to NHIC with the appropriate diagnosis code. Providers may bill for charges incurred up to $1,000 per occurrence. Justification and billing detail are no longer submitted with the claim, but they must be available in the client's file. The RFPPS will review such documentation during the agency's site review. Original date of surgery, IUD insertion, or implant insertion must be recorded in field 31 on the 2017 claim form.

SECTION 7 CLAIM/ENCOUNTER APPEAL PROCESS

1. Family Planning (Program 300) Claim Denials Due to Late Filing

An appeal for claim denial with the Texas Department of Health's (TDH) Family Planning Division — Titles X and XX — is a request for reconsideration of a claim that has been denied by the National Heritage Insurance Company (NHIC) in the *Compass 21* billing and reporting system due to filing the claim beyond the 120-day deadline. To qualify for consideration, claims must have appeared on a *Compass 21* "Remittance and Status Report" (R&S) report and have been finalized with a status of 'denied' with EOB 00295 — *Title V and XX family planning claims must be filed w/in 120 days of DOS except as noted in the family planning section of the provider procedure manual*.

All appeals of these denied claims for program services funded by Titles X and XX are addressed solely by Family Planning Division staff, and their dispensation is determined only by Family Planning Program staff.

Titles X and XX appeals must first be sent to the Regional Family Planning Program Specialist (RFPPS) who serves the project. The appeals must be received within 180 days from the date of disposition of the *R&S* report on which that claim appears. When the 180-day appeal deadline falls on a weekend or holiday, the deadline will be extended to the next business day.

The RFPPS should be contacted <u>in writing</u> regarding an appeal request. When writing the RFPPS, the provider should:

Submit copies of the R&S reports with the details on the claims in question marked for easy identification, e.g., date of submission, amount of claim, TPI.

Give the reason(s) why the denial should be rescinded, e.g., loss of staff causing delayed submission of claims within prescribed time lines.

Send any documentation that supports the provider's reasons for requesting the appeal.

The RFPPS will consider the circumstances and recommend whether the appeal is justified. The RFPPS will forward the appeal to the Family Planning Division in the TDH central office for final determination. The RFPPS will notify the provider in writing (either by mail or by E-mail) of the decision and provide reasons for denial, when that occurs. Family Planning staff will notify NHIC staff when program appeals have been approved and the earlier claim dispensation should be changed.

2. Inappropriately Paid Items on Claims, Other Claims Issues

For circumstances where items on claims were paid inappropriately (under- or over-paid) the provider should appeal those items on the claim by contacting the NHIC Customer Service hotline at 1-800-925-9126 for assistance with the matter. The provider may ask their RFPPS to assist in process; however, NHIC is the party responsible to the provider for remedying claims issues of this sort.

The provider should follow the processes outlined in the current Medicaid manual for initiating and completing this type of appeal. [Refer to Section 5 in that manual.]

When resolution through NHIC does not occur or is not satisfactory according to Family Planning Program rules, policies, and procedures, the provider should contact their RFPPS to make him or her aware of the situation and to seek assistance/intervention in dealing with NHIC.